U.S. Department of Labor

Office of Administrative Law Judges
Heritage Plaza Bldg. - Suite 530
111 Veterans Memorial Blvd
Metairie, LA 70005

(504) 589-6201
(504) 589-6268 (FAX)

Issue Date: 14 April 2004

CASE NO.: 2003-LHC-1001

OWCP NO.: 06-166889

IN THE MATTER OF:

LILA KENDRICK, WIDOW OF
JOHN C. KENDRICK (DECEDENT)

Claimant

v.

ALABAMA DRY DOCK &
SHIPBUILDING CORPORATION

Employer

APPEARANCES:

MITCHELL G. LATTOF, JR., ESQ.

For The Claimant

WALTER R. MEIGS, ESQ.

For The Employer

BEFORE: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Lila Kendrick (Claimant) widow of John C. Kendrick (Decedent) against Alabama Dry Dock & Shipbuilding Corporation (Employer).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of

Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on September 24, 2003, in Mobile, Alabama. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered 30 exhibits, Employer proffered 17 exhibits which were admitted into evidence along with one Joint Exhibit. This decision is based upon a full consideration of the entire record.[1]

Post-hearing briefs were received from Claimant and Employer by the brief due date of November 10, 2003. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. That Decedent died on September 25, 2000.

2. That there existed an employee-employer relationship at the time of Decedent's injury. Decedent was employed by Employer at various times during the years 1942, 1943, 1944, 1964, 1966, 1967, 1968, 1969, 1970 and 1971.

3. While Employer does not admit to the fact of Decedent's asbestos exposure, any exposure to asbestos which Decedent may have had while employed by Employer occurred within the course and scope of his employment.

4. That Employer was notified of Decedent's death and notice of claim letter on June 20, 2002.

5. That Employer filed a Notice of Controversion on July 19, 2002.

6. That no informal conference before the District Director was held.

[1] References to the transcript and exhibits are as follows: Transcript: Tr.___; Claimant's Exhibits: CX-___; Employer's Exhibits: EX-___; and Joint Exhibit: JX-___.

7. Claimant received no death benefits or funeral expenses.

8. That if Claimant is entitled to compensation benefits, such benefits would be based on the National Average Weekly Wage in effect on the date of Decedent's death, which is $450.64. However, pursuant to Section 9(e)(2) of the Act, the compensation rate would be capped at $150.00 per week.

9. That medical benefits for Decedent under Section 7 of the Act are not applicable.

II. ISSUES

The unresolved issues presented by the parties are:

1. Whether Decedent was exposed to harmful levels of asbestos while employed by Employer.

2. Whether Decedent's death was caused or contributed to by asbestos exposure.

3. Amounts, duration and type of any compensation due Claimant.

4. Amount of funeral expenses due Claimant.

5. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Ruby Fay Owens, the daughter of Claimant, testified on her behalf at the formal hearing. She explained that Claimant was in poor health and could not attend the formal hearing. (Tr. 17).

Ms. Owens testified that Decedent and Claimant were married on July 16, 1938 and lived together continuously as husband and wife until Decedent's death on September 25, 2000. (Tr. 17; CX-2). Claimant never remarried after Decedent's death. (Tr. 18).

She stated that Decedent was retired from Employer at the time of his death. (Tr. 18). Although he performed some part-time work selling produce, cutting trees and clearing fields for other employers in 1980 to 1982, he continued to receive his Social Security Retirement Benefits. (Tr. 29).

Ms. Owens testified that Decedent's health took a turn for the worst about five or six years before his death. (Tr. 19-20). She was not present when Decedent passed away. (Tr. 20).

John G. Lambert

On August 23, 2003, Mr. Lambert executed an affidavit in this matter in which he stated that "during the years from 1964-1971" he "regularly worked side by side with John C. Kendrick." He noted that they "occasionally used lightweight dust masks while spray painting," most of the time they wore no masks, respirators or any other protective equipment to reduce their exposure to asbestos dust. He further stated that he and Decedent tore out and removed asbestos insulation from boilers and steam pipes aboard ships at Employer's shipyard, cleaned up and removed asbestos materials from ships, performed work in close proximity to and periodically assisted insulators, boilermakers, pipefitters and other workers who were working with asbestos materials. He affirmed that he personally witnessed Decedent being exposed to and breathing the asbestos dust which was in the air from such operations. (CX-26).

Mr. Lambert also testified at the formal hearing. He stated he worked for Employer from 1956 to 1988, when the facility closed down. (Tr. 25). His Social Security Itemized Statement of Earnings reveals he worked for Employer from 1955 to 1964, 1966, and from 1973 to 1989. (CX-26, pp. 4-5, 13-14). He did not work for Employer in 1965 and from 1967 to 1973. (Tr. 25). His earning records and testimony reveal that he only worked with Decedent for three quarters in 1964 and one quarter of the year in 1966, contrary to assertions made in his affidavit. (Tr. 27-28, 29). Mr. Lambert worked for other employers in the years of 1965 and 1967-1973. (Tr. 32-39; CX-26, pp. 6-13).

The Medical Evidence

I. Harrison Moore, M. D.

Dr. Moore's records reveal that he examined Decedent on November 17, 1993, for sneezing and allergic Rhinitis. On

January 24, 1994, Dr. Moore noted that Decedent had been sent by his lawyers "to get a x-ray to see if I think there is asbestosis." X-rays were made which Dr. Moore determined were "inconclusive," and showed "a little bit patchy areas could be asbestosis." He concluded a CT scan of the lungs was needed "to be sure." (CX-19, p. 2).

Robert G. Fraser, M. D.

Dr. Fraser, who is a board-certified radiologist and Professor Emeritus of the Department of Radiology for the University of Alabama at Birmingham, reviewed chest x-rays of Decedent on January 15, 1994. The specific chest x-rays are not further identified. He determined the x-rays were of ILO quality 1 and revealed diffuse interstitial lung disease classified as "s/t irregular opacities of 1/1 profusion affecting predominantly the mid and lower lung zones." The lungs were also the site of diffuse emphysema. Pleural plaques were also identified on the left hemidiaphragm.

Assuming a history of exposure to asbestos dust of sufficient concentration over a sufficient period of time, Dr. Fraser opined that the pulmonary and pleural abnormalities described above were consistent with diagnoses of asbestosis and asbestos-related pleural disease. (CX-12; CX-13).

Peter A. Petroff, M. D.

Dr. Petroff, who is board-certified in Internal and Pulmonary Medicine and is the Medical Director of the Respiratory Therapy Department of the Southwest Texas State University, examined Decedent on June 17, 1994. (CX-14). Decedent was 88 years old at the time of the examination and complained of "mainly weakness" and was short of breath, which comes and goes. Dr. Petroff reported that Decedent had quit smoking 50 years ago, and retired 20 years before the examination. Decedent reported various past employment in which he worked with asbestos fibers and insulation as a chipper and calker in the shipyards.

Dr. Petroff opined that Decedent's chest x-rays of January 14, 1994 revealed extensive reticular interstitial changes in both the right middle lobe and lingula, as well as hyperinflation and flattening of the diaphragms. Pulmonary function studies performed showed "severe obstructive restrictive disease as evidenced by a vital capacity of 57% of predicted with an FEV1 of 48% of predicted and MMF of 29% of

predicted. The DCO and RVTLC ration were normal." (CX-15, p. 1).

On physical examination, Dr. Petroff detected decreased breath sounds in Decedent's lungs, with no wheezes, but crackles when Decedent is sitting up. Dr. Petroff's impressions were that Decedent "has significant asbestosis as evidenced by his history of exposure, as well as by the findings on the chest x-ray which are quite consistent with it. In addition, the pulmonary function studies are abnormal." Dr. Petroff opined that since Decedent "has not smoked in 50 years," he did "not think this [smoking] is the proximate cause of the changes noted on the x-ray or on the pulmonary function studies." He further opined that most of Decedent's shortness of breath is secondary to the asbestosis. (CX-15, p. 2).

K. Scott Saucier, M. D.

Dr. Saucier, whose credentials are not of record, performed pulmonary function studies of Decedent on May 27, 1994. (CX-16). He reported that spirometric studies showed a severe reduction in forced vital capacity with reduced FEV1. A mild reduction in residual volume, total lung capacity and FRC was also revealed. Diffusion lung capacity was within normal limits. His final impression was that the studies disclosed a severe degree of ventilatory impairment which had characteristics of being both obstructive and restrictive in nature. (CX-16, p. 1).

Mobile Infirmary Medical center

Dr. J. Russell Cunningham, whose credentials are not of record, interpreted a x-ray of Decedent on November 26, 1994. He concluded the lungs were irregularly hyperinflated with diffuse bilaterally scarring consistent with COPD. His impression was there existed a "questionable right lung nodule superimposed on a background of COPD." (CX-20; EX-11, p. 6).

Atmore Community Hospital

On March 7, 2000, Dr. Larry Arcement interpreted a chest x-ray and CT scan performed on Decedent. The x-ray showed an interstitial infiltrate in the right middle lobe with some chronic lung changes noted throughout with hyperextended lungs and irregular hyperaeration consistent with COPD. The CT scan revealed "a number of pleural plaques, some of them being partially calcified consistent with pulmonary asbestosis."

Prominent interstitial changes with perhaps diffuse fibrosis were also revealed. Dr. Arcement's pertinent impression was changes in the lung and pleura from pulmonary asbestosis and some pulmonary fibrosis involving both lungs. (CX-17; EX-12, p. 45).

On March 13, 2000, Decedent was admitted into the hospital with complaints of hemoptysis (coughing up blood). (CX-29, p. 14). He was discharged on March 24, 2000, by his attending physician Dr. Pamela Gibbs. Biopsies for lung cancer were all negative, however Dr. Gibbs opined that Decedent "does have significant asbestosis of the lung and had previous tobacco history for about 50 years, none over the last 20 years." On admission, Decedent's lungs were clear with some mild decrease at the bases and occasional rhonchi with "cough cleared." (CX-18, p. 2; EX-12, p. 76). A chest x-ray on admission revealed diffuse reticular opacities at both lung zones compatible with chronic lung disease. (CX-18, pp. 3, 5; EX-12, p. 77). On March 14, 2000, "rales were noted in the left lung." (EX-12, p. 132). The discharge summary noted the prescription of Lasix "because of few crackles in his lungs." (CX-18, p. 3). Dr. Gibbs opined that Decedent "probably has SIADH from an undiagnosed lung cancer," but did not want to undergo any further treatment. (CX-18, p. 4). Before his hospitalization, Decedent underwent a bronchoscopy on March 7, 2000, which disclosed a benign bronchial wall and respiratory mucosa. (CX-18, p. 10; EX-12, p. 22).

On September 11, 2000, Decedent, who was 94 years old, was re-admitted to the hospital with complaints of aching all over and was discharged on September 16, 2000. Pneumonia was seen on his x-ray as well as plaque, as well as "some chronic interstitial changes and blunting of the costophrenic angles consistent with chronic lung disease and COPD." (CX-18, pp. 16, 22; EX-12, pp. 248-250).

Dr. Roy Gandy performed a consultation on September 14, 2000, at Dr. Moore's request. On physical examination of the chest, scattered rales and rhonchi were present. Dr. Moore reported hearing no rales or rhonchi on September 11, 2000. (CX-18, p. 19; EX-12, p. 251).

On September 13, 2000, Decedent had an episode of congestion, shortness of breath and tachypnea. Dr. Moore reported that "his lungs are rales and the bases are bilaterally." (CX-18, p. 20). A chest x-ray done on September 13, 2000, showed chronic lung disease. (CX-18, p. 21).

Pamela J. Gibbs, M. D.

Dr. Gibbs was deposed by the parties on August 26, 2003. (CX-29; EX-14). Since her residency, she has practiced internal medicine for five years in Atmore, Alabama. (CX-29, p. 7). She examined Decedent twice while he was hospitalized, but did not treat him routinely since he was Dr. Moore's patient. (CX-29, pp. 8-9). She completed the certification part of the Decedent's Certificate of Death. (CX-29, pp. 9, 42). She acknowledged that Dr. Moore completed the Physician Attestation Statement reflecting the admitting, principal and secondary diagnosis for Decedent's September 11, 2000 hospital admission. (CX-29, pp. 10, 43).

Dr. Gibbs stated she completed the Certificate of Death since she was on-call for their medical group of which Dr. Moore is a practitioner. She included Decedent's asbestosis among the secondary or contributing causes on the Certificate of Death, based on his family's report that he had a history of asbestosis. (CX-29, pp. 13-14). She also recalled admitting Decedent into the hospital in March 2000 at which time his chest x-ray showed pleural plaques with some calcification which may be diagnostic of asbestosis. Dr. Gibbs testified that further work-up with a CT scan indicated Decedent did, in fact, have evidence of asbestosis based on the interpretation of the radiologist, Dr. Arcement, which included pleural plaques with calcification and interstitial lung changes that may also be diagnostic of asbestosis. (CX-29, pp. 14, 50).

Dr. Gibbs could not recall whether she personally reviewed the x-rays and CT scan, but it is her custom to do so. (CX-29, p. 15). Dr. Luke Adams's interpretation of a chest x-ray of March 13, 2000, revealing the presence of "diffuse reticular opacities at both lung zones compatible with chronic lung disease" confirmed, according to Dr. Gibbs, that Decedent continued to have bilateral lung processes and evidence of lung changes consistent with asbestosis. (CX-29, pp. 18, 45; EX-12, p. 112). Dr. Gibbs explained that reticular opacities "may be speckled-looking" on a chest x-ray and linear opacities "almost falls in little lines . . . almost continuously." (CX-29, p. 19). Dr. Gibbs testified that she would initially think of pneumonia when reticular opacities are present, but that does not include any other symptoms. (CX-29, pp. 19-20). Decedent's admitting diagnosis of pneumonia on March 6, 2000, correlates to the x-ray reading by Dr. Adams. (CX-29, pp. 21, 47).

Dr. Gibbs testified that Decedent had a documented 50-year history of smoking one pack of cigarettes per day. (CX-29, p. 23). Dr. Gibbs's final diagnosis included, inter alia, "pulmonary fibrosis, asbestosis" based on chest x-rays which showed "severe COPD with interstitial infiltrate" and a CT scan which revealed "pleura from pulmonary asbestosis, pulmonary fibrosis in both lungs . . . ." (CX-29, pp. 23-24, 48). She further stated that, in addition to pleural thickening, Decedent had plaques with calcification. She explained that the diagnosis of pleural thickening caused by asbestosis is based on calcification of the pleural plaques and the patient's history of asbestosis. (CX-29, p. 26).

Dr. Gibbs did not examine Decedent following his death on September 25, 2000, nor was an autopsy performed to her knowledge. She explained that the cause of death reflected on the Certificate of Death was determined from information provided by the hospice nurse to the medical examiner which is correlated to the history known by the certifying physician. (CX-29, p. 28). She further stated that the immediate cause of death listed on the Certificate of Death, respiratory failure, "must have been determined after I spoke with the medical examiner." She acknowledged that lung cancer as a secondary or a contributing cause to respiratory failure was a presumptive diagnosis in the absence of a biopsy. (CX-29, pp. 29-30). The third diagnosis of asbestosis of the lung was based on Decedent's previous history and the CT scan of March 7, 2000. The fourth diagnosis of COPD was based on clinical findings and Decedent's chest x-rays and CT scan. (CX-29, p. 30).

Upon reviewing Dr. Petroff's report of June 17, 1994, Dr. Gibbs acknowledged that a finding of normal diffusion of carbon monoxide and RVTLC should be decreased if extensive fibrosis exists, but that a normal respiratory volume of total lung capacity could be expected in a person with asbestosis-related disease. (CX-29, p. 32). Dr. Gibbs noted however that Decedent's vital capacity was 57% which is inconsistent with a normal respiratory finding. (CX-29, p. 33).

On cross-examination, Dr. Gibbs clarified that codes placed on coder sheets for diagnoses are not necessarily the opinions of the physicians. The final diagnoses on a discharge summary reflects the opinions of the physicians. (CX-29, pp. 35, 43). Dr. Gibbs also explained that patients who use tobacco and have exposure to asbestos significantly increase the risk and probability of contracting lung cancer. (CX-29, p. 36).

Gaeton Don Lorino, M. D.

Dr. Lorino, who is board-certified in Internal Medicine and Pulmonary Medicine, was deposed by the parties on September 4, 2003. (CX-30, p. 45). He is presently in private practice with Montgomery Pulmonary Associates in Montgomery, Alabama. (CX-30, p. 5).

Dr. Lorino testified that from 1985 to 1995 he performed "many evaluations of people who have possible asbestosis or occupational lung disease." He has given talks to the medical community and community groups in Mobile, Alabama, regarding asbestos. (CX-30, p. 6). He assisted The City of Mobile in screening "a number of their firemen for possible asbestos-related lung disease." (CX-30, pp. 6-7). He is familiar with Dr. Irving Selikoff who published a number of papers regarding the subject of asbestosis and who had one of the largest "cohorts" [study groups] for asbestosis, over 17,000 insulator workers. He was part of a screening done with Dr. Selikoff "looking at maritime workers" 10 to 15 years ago. (CX-30, p. 7).

Dr. Lorino explained that asbestos products are harmful to persons when they are cut or torn producing fibers which become airborne and can be inhaled into the lungs. (CX-30, p. 8). Such fibers can penetrate through air sacks into the chest wall causing scarring in the lung, which decreases volumes of the lung with resulting decreased ability to deliver oxygen into the bloodstream. Asbestos can cause pleural plaques by irritating the lining of the chest wall causing thickening or cartilage-type material to be deposited on the chest wall. (CX-30, p. 9). He opined there have been no demonstrable safe levels of asbestos exposure. (CX-30, p. 10).

Dr. Lorino was consulted to render an opinion whether Decedent's asbestos exposure contributed to his death. (CX-30, p. 11). He did not conduct a medical examination of Decedent. He reviewed Decedent's work history sheets and the affidavit of John Lambert (Exhibits 2 and 3 to Dr. Lorino's deposition) which revealed Decedent had been exposed to various asbestos-containing products about 100% of the time during 14 years of employment. He opined that Decedent had "significant exposure to asbestos at least to the point of being enough to cause him to develop asbestosis over time." (CX-30, p. 13).

Dr. Lorino examined the chest x-ray report of Dr. Fraser, the June 17, 1994 report of Dr. Petroff, the June 2, 1994

pulmonary function study of Dr. Saucier, the CT scan of March 7, 2000 at Atmore Community Hospital, various records of Dr. Moore and Decedent's Certificate of Death (Exhibits 4 through 9 of Dr. Lorino's deposition). He testified that Decedent had both pleural plaque formation as well as pulmonary fibrosis. (CX-30, pp. 13-15). Dr. Lorino observed that Decedent had documented inspiratory rales on physical exam and COPD on his pulmonary function test and, in his opinion, "certainly" had pulmonary asbestosis. (CX-30, pp. 15-16). Decedent had two lung problems, COPD and pulmonary asbestosis, and there was a question whether he also had lung cancer. (CX-30, p. 16).

Dr. Lorino stated that he personally reviewed some of Decedent's chest x-rays which demonstrated changes of pulmonary fibrosis in the base of his lungs, pleural plaques of the diaphragm, hyperexpanded lung fields and flattening of the diaphragm. (CX-30, p. 17). He indicated that the pleural plaques and fibrosis were significant factors in reaching a conclusion that Decedent had asbestosis. (CX-30, pp. 17-18). Dr. Lorino testified that Decedent had completed a sheet which indicated he smoked two packs of cigarettes a day "for about 20 years," but had not smoked for 50 years prior to his death. (CX-30, p. 18; CX-30, Exh. 10). He opined that Decedent's smoking history would have no effect on his opinion that he had asbestosis, whether he smoked for 20 or 50 years. He opined that Decedent's exposure to asbestos contributed to his death in terms of pulmonary dysfunction, as "one of the diseases that he had along with obstructive lung disease." (CX-30, p. 19).

On cross-examination, Dr. Lorino testified that Decedent's diffusion capacity on his 1994 pulmonary function study was normal which is not inconsistent with the presence of asbestosis. (CX-30, pp. 21-22). He added that an individual can have asbestosis (restrictive lung disease) and pulmonary fibrosis and still have normal diffusion capacity. (CX-30, p. 23). Dr. Lorino stated that certain parameters of a pulmonary function study indicate or are consistent with asbestosis, such as restrictive lung disease, reduced diffusion capacities and reduced vital capacities, of which Decedent had restrictive lung disease and reduced vital capacity. (CX-30, p. 24). Although there are 140-150 lung diseases which cause restrictive lung disease and pulmonary fibrosis, Dr. Lorino opined only one interstitial lung disease causes such changes when asbestos exposure, pleural plaques and fibrosis are present, and that is pulmonary asbestosis. (CX-30, p. 25).

Dr. Lorino further opined that Decedent exhibited significant exposure, significant latency, radiographic abnormalities, pulmonary function test abnormalities and rales on physical exam, which are the five criteria for diagnosing pulmonary asbestosis. (CX-30, pp. 25-26). Dr. Lorino observed linear and reticular markings in the bases of Decedent's lungs and pleural plaques in the left diaphragm. (CX-30, pp. 26-27). He noted that pleural plaques do not infer or cause pulmonary dysfunction and are "not felt to be indicative of any sort of problems with pulmonary function testing." (CX-30, pp. 28-29). However, he stated pleural plaques may have had an affect on Decedent's respiratory capacity since he also had restrictive lung disease and fibrosis. He observed that Decedent had a moderate reduction in vital capacity on his 1994 pulmonary function study. (CX-30, p. 29). He "guessed" that Decedent's pulmonary function study results would be classified as a Class two or three under the Guides to the Evaluation of Permanent Impairment. (CX-30, p. 30).

Dr. Lorino confirmed that COPD would contribute to Decedent's shortness of breath and affect his respiratory and vital capacities. He added that Decedent had two problems (COPD and asbestosis) and both were contributing, and nothing on the pulmonary function study "will allow you to say that one disease was worse than another." He opined that individuals who have an obstructive lung disease and a superimposed restrictive lung disease will have more symptoms. (CX-30, p. 31). Obstructive lung disease causes increased lung volumes and total lung capacity should be well within normal limits. However, Decedent had reduced lung volume and reduced total lung capacity which indicates he had restrictive and obstructive lung processes. (CX-30, pp. 32-33). Dr. Lorino opined that there was no way to attribute a percentage of cause to either process, but it was not possible that only one disease could be causing all of Decedent's symptoms and study results. (CX-30, p. 33).

Based on the 1994 pulmonary function study, Dr. Lorino characterized Decedent's obstruction problem at 70% or as a mild to moderate degree of air flow. (CX-30, p. 35). Decedent's reduced vital capacity was around 50% or moderate and lung volumes were reported at 72% of predicted or mildly reduced. (CX-30, pp. 35-36).

Dr. Lorino opined that Decedent had respiratory dysfunction, respiratory failure was listed as his cause of death and asbestosis contributed to his death. (CX-30, p. 38).

John B. Bass, Jr., M. D.

Dr. Bass, who is board-certified in Internal Medicine and Pulmonary Medicine, was deposed by the parties on September 17, 2003. (EX-17, p. 6). Dr. Bass is currently a Professor and Chairman, Department of Internal Medicine at the University of South Alabama, College of Medicine. (EX-17, pp. 65-66).

Dr. Bass testified that he has examined "about a thousand" patients who complained of problems due to asbestos exposure during the last 25 years. (EX-17, p. 7). In preparation for his opinion in this matter, Dr. Bass reviewed various medical reports and records of Decedent from hospital visits in 1994 and emergency room and hospital visits in 2000, as well as his Certificate of Death. (EX-17, p. 8). He did not examine Decedent before his death. He testified that he had enough information to formulate "some opinions," but "there's some information that would give me better—-would make it easier for me to make a better opinion that I don't have." (EX-17, p. 9). He specified such additional information would include pulmonary function studies and "blood gases towards the end of [Decedent's] life." (EX-17, p. 10).

Dr. Bass opined that Decedent's major respiratory problem was chronic obstructive pulmonary disease as reflected in air flow obstruction on his pulmonary function study, distended lungs with low flat diaphragms on his chest x-ray film and a long history of cigarette smoking. He stated that Decedent's CT scan showed some areas that are probably pleural plaques which he thought were reasonably "related to his asbestos exposure." He noted Decedent also had "some increased markings on some of the x-ray film and on the CT scan which possibly could be parenchymal asbestosis," but which cleared up on x-ray films after March 2000. (EX-17, pp. 11-12). He added that "the latest films and the earliest films are very similar looking. The films taken during March [2000] look a lot worse." (EX-17, p. 12).

Dr. Bass testified that he did not see any convincing evidence that Decedent had a pneumoconiosis related to asbestos. The x-ray film and CT scan showed increased markings in March, 2000, but the x-rays, which were of poor quality according to Dr. Bass, "appear to get better." Dr. Bass indicated the poor quality of the films "might tend to understate" the markings, but may tend to overstate them as well. He preferred to have better quality films. He saw no evidence of any progression in the markings, but exactly the opposite. (EX-17, p. 14). He

stated he saw evidence of regression in the markings. He opined that since Decedent was in his nineties, such markings might not progress much, but he "would expect them not to regress." He saw no evidence of any other diseases that Decedent might have had which would have been related to asbestos exposure. (EX-17, p. 15). He saw no evidence of lung cancer or mesothelioma. (EX-17, p. 16).

Dr. Bass testified that based upon his review of the medical data presented to him, there was not enough evidence for him to agree with the principal cause of death (respiratory failure) listed on Decedent's Certificate of Death. He stated there was no way for him to determine the cause of death "at this point" based on such medical records. He testified that Decedent had a compromised respiratory system and that the percentages reflected in the 1994 pulmonary function study would be enough "to perhaps cause him some symptoms, but not enough to kill him." (EX-17, p. 17). He added that such percentages were "probably not enough to significantly contribute to his death." Dr. Bass thought he had reviewed an arterial blood gas study, which he could not locate in the medical records, but stated the results were not "severely enough abnormal to really be associated with his death." (EX-17, p. 18). He subsequently testified he was not sure the blood gas study had much bearing on his opinion, because the pulmonary function study would be more important. (EX-17, pp. 19-20). He admitted that "perhaps I'm mistaken in thinking I did see some blood gases." (EX-17, p. 20).

Dr. Bass testified he saw "no evidence whatsoever that the [Decedent] had cancer of the lung." Decedent had both x-rays and a CT scan and a bronchoscopy, which are the tests used to investigate lung cancer, and no evidence of cancer was detected. (EX-17, p. 21).

Dr. Bass did not believe there was sufficient evidence to conclude Decedent had asbestosis of the lung. He stated the characteristic symptoms of asbestosis are shortness of breath and sometimes a nonproductive cough. There is mention in Decedent's records of a cough once or twice when he had pneumonia and shortness of breath. (EX-17, pp. 22-23). He also stated that characteristic physical findings of asbestosis, according to the American Thoracic Society Statement On The Diagnosis of Nonmalignant Diseases Related to Asbestos (ATS), are crackles, pulmonary function abnormalities, radiographic abnormalities and clubbing, which is rare. (EX-17, pp. 23-24).

Dr. Bass did not find a "single instance of anyone hearing crackles" or any evidence of clubbing. (EX-17, p. 24).

Dr. Bass interpreted Decedent's pulmonary function study as showing a low vital capacity and an even lower FEV1, indicating air flow obstruction, and "a normal diffusing capacity which would be decidedly against significant asbestosis." He could not make a conclusive diagnosis of asbestosis from the x-rays or CT scan. He observed the x-rays and CT scan "during the March [2000] admission show some areas that could be pulmonary fibrosis. They appear to get better on the plain films subsequent to that period of time." (EX-17, p. 25).

Dr. Bass stated there was evidence in the medical records and radiographic studies of chronic obstructive pulmonary disease in that Decedent had overextended lungs with flat diaphragms on chest x-ray, a history of cigarette smoking and obstruction on his pulmonary function study consistent with COPD. Such findings are not suggestive of asbestosis or thought to be caused by asbestos exposure according to Dr. Bass. (EX-17, p. 26).

Dr. Bass prepared a letter to Employer on June 17, 2003, based upon reviewing the medical data made available to him, which did not include the x-ray films. (EX-17, p. 27; EX-15). He concluded that the only diagnosis listed on Decedent's Certificate of Death which was confirmed by existing medical records then available to him was chronic obstructive pulmonary disease. He noted that there was not enough information to confirm a diagnosis of lung cancer or pulmonary asbestosis. (EX-15, p. 1).

Dr. Bass disagreed with Dr. Gibbs's diagnosis of pulmonary fibrosis secondary to asbestos exposure. He opined Dr. Gibbs reached such a finding because "she thought she saw some interstitial infiltrates," and Decedent told her he had a history of being evaluated for asbestos-related disease. (EX-17, p. 29). Dr. Bass affirmed he did not think there was enough evidence on x-rays to make a diagnosis of asbestosis. (EX-17, 30).

Upon reviewing Dr. Fraser's report of January 15, 1994, for the first time at deposition, Dr. Bass testified that he saw nothing in the report which would alter his opinion. (EX-17, p. 33).

Upon reviewing the pulmonary function study conducted by Dr. Saucier in June 1994, Dr. Bass stated that Decedent had severe ventilatory impairment with air flow obstruction and his diffusing capacity was actually higher than normal, which was "a remarkably good diffusing capacity." He explained that the normal reading was problematic because the normal numbers are based on the general population which accounts for age, sex and height and, since Decedent was 94 years old, "the predicted values become a little bit suspect." Dr. Bass opined that if Decedent had asbestosis, "still the majority of his impairment [was] an obstructive impairment due to chronic obstructive pulmonary disease." (EX-17, pp. 35, 36).

Dr. Bass further opined that Decedent's higher than normal diffusing capacity would indicate that he did not have much damage to the lung substance itself either from asbestosis or from anatomical emphysema. Dr. Bass also stated he was reasonably sure the lung volumes appearing on the pulmonary function study were performed by the nitrogen washout techniques which tend to underestimate total lung volumes and capacity in people with obstructive lung disease. (EX-17, p. 36).

On cross-examination, Dr. Bass expressed agreement with Dr. Saucier that the literal numbers reflected on the pulmonary function study presented characteristics of being both obstructive and restrictive in nature. However, he questioned the accuracy of the resulting numbers. Based on his assumption that the nitrogen washout technique was used, he opined "falsely low lung volume measurement" resulted which would remove the restrictive defect. Dr. Bass acknowledged that no other numbers from any other pulmonary function study was available. He noted a restrictive ventilatory impairment can be caused by asbestosis. (EX-17, pp. 38-39). He confirmed that there was no way to separate how much impairment is considered obstructive or restrictive. However, he opined that of the two components, the air flow obstruction was severe and more of a contributing factor than the restriction which was only borderline. (EX-17, p. 40).

Dr. Bass testified that the required criteria he follows in diagnosing asbestosis are a history of exposure, characteristic radiographic and pulmonary function abnormalities in addition to symptoms and physical findings which are useful, but not necessary. (EX-17, p. 42). Dr. Bass agreed that the information presented to him of Decedent's history of exposure and latency period satisfied his requirements for an asbestosis diagnosis, however he noted there was no way of reconstructing

how much asbestos to which Decedent was exposed. He did not agree that the radiographic evidence would satisfy his requirement for asbestos disease, commenting "that's not to say it wasn't there, but it would not satisfy my criteria entirely because I believe there are other possible explanations for the major abnormal radiographs . . . ," including pneumonia. (EX-17, pp. 43-44). He reiterated that none of Decedent's x-rays, except the CT scan, were of good quality. He stated the March 2000 films "looked to me worse than the radiologist is reading them." The earlier films "look about the same but they're not good quality films." (EX-17, p. 45). He further testified that Decedent's x-ray films were overexposed which tend to decrease the markings on the films. Because of the poor quality of the films, Dr. Bass agreed it was reasonable to conclude he could not make a determination as to whether there had been any progression of fibrosis, if it exists, between 1996 and the last films. (EX-17, p. 46).

Dr. Bass testified that he would need some sort of an encounter around the time of Decedent's death indicating that he was having respiratory difficulty, such as a medical examination, to render an opinion that Decedent died of respiratory failure. (EX-17, pp. 46-47). Dr. Bass agreed it was a reasonable assumption by the physician to suspect Decedent may have had lung cancer because of his low serum sodium concentration and his prior smoking history and asbestos exposure. (EX-17, p. 47). However, he saw no evidence of lung cancer. (EX-17, p. 48).

Dr. Bass testified the significance of the presence of crackles is that the most likely thing to cause crackles would be pulmonary fibrosis. He acknowledged that Dr. Petroff documented crackles when Decedent was sitting up, but that other doctors had not. He opined that crackles from pulmonary fibrosis do not go away. He stated crackles from other causes come and go such as from secretions, pneumonia, obesity, and waking up in the morning. (EX-17, p. 49). He also acknowledged that Dr. Fraser authored a book entitled Differential Diagnoses of Diseases of the Chest which is still recognized and accepted as a reference book in his profession. (EX-17, p. 50).

On re-direct examination, Dr. Bass testified that if the pulmonary function numbers were accurate "it might mean that [Decedent] had two diseases, that he had chronic obstructive pulmonary disease and pulmonary fibrosis." (EX-17, p. 51). Dr. Bass opined that based on the pulmonary function numbers Decedent had a major obstructive defect and his restrictive

defect, if he had one, was relatively minor. The obstructive defect was due to COPD. (EX-17, p. 52). When asked to assume that Decedent did have a restrictive defect and to speculate on whether it was severe enough to have any practical effect on Decedent's respiratory capacity, Dr. Bass responded "That's a difficult question to answer. And the reason I say that is that if you have a severe defect from one disease and another disease makes it a little bit worse, you might be worse." (EX-17, p. 54). However he stated he did not think there was any clear evidence that Decedent was worse. (EX-17, pp. 54-55).

Dr. Bass further testified that if fine interstitial markings, particularly in the posterior lower lung zones, in a prone CT scan are seen it is fairly suggestive of pulmonary fibrosis, but that no such markings are seen on Decedent's CT scan. (EX-17, p. 57). He opined that anatomical emphysema markings crowd out the other lung markings and start looking like fibrosis because the emphysema areas are actually gone, "there's nothing there," and radiologists frequently read such increased markings as pulmonary fibrosis. (EX-17, pp. 57-58). Emphysema markings are not reversible, but what looked terribly abnormal in the March films did not look so terribly abnormal to Dr. Bass in the September 2000 films. (EX-17, p. 58). He added that too much is being made of the films, "because even if [Decedent's] got asbestosis, I don't think he's got very much of it," and it did not contribute to his death. Dr. Bass further opined that Decedent's obstructive lung disease did not make him die either, "so I don't know why he died." He stated that there was not evidence of any progressive markings in Decedent's lungs between 1996 and September 2000. (EX-17, p. 59).

Other Evidence

On January 30, 1990, Decedent signed a notarized affidavit in which he explained his vocational history, apparently in support of a claim filed for his loss of hearing. He affirmed that he worked as a chipper and corker in ship repair and construction for Alabama Dry Dock and Shipbuilding Corp. (ADDSCO) in 1942 through 1944 and from 1964 through 1971. He worked regularly in the double bottom of the ships and all over the vessels. He stated he last performed ship repair and construction in 1971 for ADDSCO and did not work for any other company for whom he did ship repair and construction after 1971. After employment with ADDSCO, he worked for a company installing a pipeline which did not involve ship repair, ship construction or maritime activities of any kind. (CX-22, p. 2; CX-23).

Decedent also completed a "Smoking History" form in which he reported smoking cigarettes, cigars and a pipe for 10-12 years at least, "50 years ago." He smoked two packs of tobacco per day and quit after a doctor told him to do so. (CX-21).[2]

In response to discovery filed in a third party asbestosis lawsuit, Decedent reported his employment as a chipper and corker with Atlantic Land Corp. at the ADDSCO jobsite and exposure to asbestos from 1942-1944 for a two-year period. He estimated he was exposed to asbestos 100% of his work time and indicated he did not wear a respirator, mask or other protective device to avoid inhalation of any dust or fumes including asbestos dust. He reported working "around" asbestos materials used on boilers, pipecovering, gaskets, packing and insulating cement. (CX-24, p. 8). He also reported working at the ADDSCO jobsite from 1964 to 1971 as a chipper and corker where he was exposed to asbestos products 100% of his work time and did not wear protective devices. During this later period, Decedent reported working with asbestos materials in sheet gaskets, packing and joint compound. He also reported working around asbestos materials in the form of felt/cloth, sheet gaskets, packing, joint compound pipecovering, refractory cement, gun mix, firebrick, boilers and turbines. (CX-24, p. 11).

The Contentions of the Parties

Claimant contends that Decedent worked for Employer from 1942 to 1944 and again from 1964 to 1971 when he voluntarily retired at the age of 66. Claimant avers that there is record evidence that Decedent was exposed to substantial amounts of asbestos during his employment at Employer. His death certificate lists respiratory failure due to lung cancer, asbestosis of the lung, and chronic obstructive pulmonary disease. Claimant relies upon the medical opinion of Dr. Lorino and other physicians that Decedent's asbestos exposure contributed to his death.

Employer relies upon the medical opinion of Dr. Bass and contends that Decedent did not have an asbestos-related disease and, even if he did, such disease had nothing to do with his death. Employer argues there is no compelling evidence of

[2] Variances appear in the record regarding Decedent's smoking history: Dr. Moore reported Decedent's tobacco use "for about 20 years" (CX-30, p. 73; Dr. Gibbs reported tobacco use "for about 50 years, none over the last 20 years" (CX-30, pp. 81, 84).

record that Decedent's lung condition caused his death other than the face of the death certificate.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

A. The Compensable Injury

In determining whether a death is work-related, a claimant is aided by the Section 20(a) presumption, which may be invoked only after the claimant establishes a **prima facie** case, i. e., the claimant demonstrates that the Decedent suffered a harm and that an accident occurred, or conditions existed, at work which **could have caused** the harm. U. S. Industries/Federal Sheet Metal, Inc. v, Director, OWCP, 455 U.S. 608, 14 BRBS 631 (1982); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT)(5th Cir. 1998); Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981).

Once the claimant establishes a **prima facie** case, Section 20(a) applies to relate the death to the employment, the burden shifts to the employer to rebut the presumption by producing substantial evidence that the Decedent's employment did not

cause, contribute to or hasten his death. Louisiana Insurance Guaranty Association v. Bunol, 211 F.3d 294, 34 BRBS 29(CRT)(5th Cir. 2000); See Peterson v. General Dynamics Corp., 25 BRBS 71 (1991)(en banc) aff'd sub nom. Ins. Co. of North America v. U.S. Dept. of Labor, 969 F.2d 1400, 26 BRBS 14 (CRT)(2d Cir. 1992), cert. denied, 113 S.Ct. 1253 (1993). The United States Court of Appeals for the Eleventh Circuit, within whose jurisdiction the instant case arises, espouses a "ruling out" standard when addressing the issue of rebuttal of the Section 20(a) presumption.[3] Brown v. Jacksonville Shipyards, Inc., 893 F.2d 294, 23 BRBS 22 (CRT)(11th Cir. 1990). The Board has explained that this standard does not require a physician to rule out all possibilities, as absolute certainties do not exist in the medical profession and such a requirement would raise the standard regarding rebuttal of the presumption to an unreachable level. O'Kelley v. Department of the Army/NAF, 34 BRBS 39 (2000). The Board held that an unequivocal opinion, given to a reasonable degree of medical certainty, that the employee's injury is not work-related is sufficient to rebut the Section 20(a) presumption. Id., at 41-42.

If the employer rebuts the presumption, it no longer controls, and the issue of causation must be resolved on the evidence of record as a whole, with the claimant bearing the burden of persuasion. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119 (CRT)(4th Cir. 1997); See generally Director, OWCP v. Greenwich Collieries, supra.

1. Claimant's Prima Facie Case-Exposure and Causation

In the present matter, I am persuaded by Counsel for Claimant's excellent brief that Claimant has established a **prima facie** case by demonstrating that Decedent suffered a harm

[3] The United States Court of Appeals for the Fifth Circuit, however, has rejected the "ruling out" standard. See Conoco v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT)(5th Cir. 1999); see also American Grain Trimmers v. Director, OWCP [Janich], 181 F.3d 810, 33 BRBS 71 (CRT)(7th Cir. 1999), cert. denied, 120 S.Ct. 1239 (2000). The United States Court of Appeals for the First Circuit has stated that the rebuttal standard does not require employer to rule out any possible causal connection between a claimant's employment and his condition as such a requirement goes far beyond the substantial evidence standard stated in the statute. See Bath Iron Works v. Director, OWCP [Shorette], 109 F.3d 53, 31 BRBS 19 (CRT)(1st Cir. 1997).

(death) which **could have been caused** by conditions prevalent at Employer's jobsite during his employment. There is no dispute that Decedent died on September 25, 2000, which satisfies the initial prong of the requirement for invocation of Section 20(a). For reasons discussed below, I also find and conclude Claimant has established that Decedent was exposed to harmful conditions at Employer's worksite and that such harmful stimuli **could have** contributed to his death.

Decedent's vocational exposure to harmful stimuli is abundantly set forth in his notarized affidavit and in responses to third-party litigation discovery. It is uncontradicted that Decedent worked as a chipper and corker at Employer's shipyard from 1942-1944 and from 1964 through 1971. He affirmed that he was exposed to asbestos in various forms 100% of his work time and did not wear any protective respirator equipment. He also worked around other crafts using asbestos materials for insulation, packing and compounding.

Although Employer successfully showed that Mr. Lambert did not work "side-by-side" with Decedent from 1964-1971, his testimony and affidavit, in pertinent part, was undisturbed and clearly describes the exposure he and Decedent endured while working at Employer's shipyard. He explained that Decedent rarely used a protective mask while spray painting and was exposed to asbestos materials and dust particles when tearing out and removing asbestos insulation from boilers and steam pipes aboard ships and working in proximity to other crafts who worked with asbestos materials.

Based on the foregoing, I find and conclude that Claimant has shown Decedent was exposed to harmful conditions at work for Employer.

Drs. Fraser, Petroff, Saucier, Gibbs, Arcement, Gandy, Moore and Lorino provided medical opinions, when taken as a composite, which establish that Decedent suffered from symptoms and findings consistent with asbestosis. Such symptoms included unproductive cough and shortness of breath. In addition to Decedent's exposure and the latency period from retirement to his death of 29 years, Decedent also exhibited physical or clinical findings, under the ATS diagnosis standards, of rales or crackles, pulmonary function study abnormalities and radiographic abnormalities. Drs. Gibbs, Moore and Lorino opined that Decedent's exposure to asbestos was a contributing cause to his death.

Thus, based on the foregoing, I find and conclude Claimant has established a **prima facie** case that Decedent suffered an "injury" under the Act, having established that he suffered a harm (death) on September 25, 2000, and that his working conditions for Employer could have caused the harm or death sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988); See Jones v. Aluminum Co. of America, 35 BRBS 37 (2001).

2. Employer's Rebuttal Evidence

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Decedent's death was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], supra; Gooden v. Director, OWCP, supra; Louisiana Ins. Guar. Ass'n v. Bunol, supra; Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT)(5th Cir. 1994). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. Avondale Industries v. Pulliam, 137 F.3d 326, 328 (5th Cir. 1998); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Employer cannot rebut the Section 20(a) presumption with either inconclusive or inadequate medical information. Williams v. Chevron U.S.A., Inc., 12 BRBS 95 (1980); See Eller & Co. v. Golden, 620 F.2d 71 (5th Cir. 1980). Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

Employer relies upon the medical opinions of Dr. Bass. Dr. Bass acknowledged that he did not examine Decedent at any time and would have liked more medical testing upon which to base his medical opinions. He did not treat or attend to Decedent during his hospitalizations, but only reviewed the work of other physicians and did not sufficiently or convincingly explain or

support his differences with other stated medical opinions of record. He would have preferred to have a pulmonary function study closer in time to Decedent's death rather than 1994, when the only pulmonary test of record was performed. He actually thought he had reviewed a blood gas study somewhere in Decedent's medical records, but could not locate the study at the time of deposition. He preferred a blood gas study with carbon dioxide readings. I found Dr. Bass's opinions were hedged on probability and possibility and rarely reflected factual explanation which could be considered reasoned.

Although he testified some areas on the March 2000 CT scan showed "probable pleural plaques" which "reasonably related to Decedent's asbestos exposure" and some areas "possibly could be parenchymal asbestosis," he saw no convincing evidence that Decedent had pneumoconiosis related to asbestos. He saw no evidence of any other diseases related to asbestos exposure. Nor did he find enough evidence to agree that Decedent died of respiratory failure. For the most part, he disagreed with Decedent's treating and consultative physicians, often without further explication.

Nevertheless, Dr. Bass opined that if Decedent has asbestosis, it was not much, and it did not contribute to his death. Accepting Dr. Bass's conclusion on lack of contribution, I find that Employer rebutted the Section 20(a) presumption. Accordingly, all of the record evidence must now be weighed to resolve the issue of causation.

3. Weighing All of the Record Evidence

The majority of the medical opinions of record support a finding and conclusion that Decedent had an asbestos-related disease which, in part, contributed to his death. For reasons discussed below, I so find and conclude.

a. Did Decedent suffer from Asbestosis?

Utilizing the criteria set forth in the ATS Statement endorsed by Dr. Bass for diagnosing asbestosis, it is clearly apparent that Decedent met or exceeded the majority of the factors considered. The ATS Statement explains that the "diagnosis of asbestosis is judgement (sic) based on a careful consideration of all relevant clinical findings." The following criteria are deemed **necessary** by the ATS Statement: (1) a reliable history of asbestos exposure: (2) an appropriate time interval between exposure and detection. As previously noted

Claimant has established that Decedent had a history of asbestos exposure which I have credited and a latency period from last exposure in 1971 to detection or diagnosis in 1994. Dr. Bass conceded that Decedent had adequate exposure and latency under this criteria.

The ATS Statement thereafter considers clinical criteria of **recognized value** as follows: (1)Chest roentgenographic evidence of type "s," "t," "u," small irregular opacifications of a profusion of 1/1 or greater; (2) a restrictive pattern of lung impairment with a forced vital capacity below the lower limit of normal; (3) a diffusing capacity below the lower limit of normal; (4) bilateral late or pan inspiratory crackles at the posterior lung bases not cleared by cough. Of the foregoing, the ATS Statement notes "findings on the chest roentgenogram are the most important. When this criteria is not met, considerable caution is warranted. The specificity of the above criteria increases with increasing numbers of positive criteria."

Dr. Fraser's interpretation of Decedent's chest x-ray on January 15, 1994, clearly fulfills the criteria established above. He determined that Decedent had diffuse interstitial lung disease classified according to the ILO 1980 system as "s/t" irregular opacities of 1/1 profusion affecting predominantly the mid and lower lung zones. Pleural plaques were also identified. Drs. Petroff, Arcement, Gibbs, Lorino and Adams interpreted Decedent's x-rays and CT scan as revealing interstitial infiltrates with diffuse reticular opacities compatible with chronic lung disease and consistent with and diagnostic of asbestosis. Furthermore, pleural plaques were observed, some partially calcified, consistent with pulmonary fibrosis and asbestosis.

Dr. Bass assessed all the x-rays of Decedent to be of poor quality, yet agreed that Decedent's x-rays suggested he had asbestosis with "some areas" that are "probably pleural plaques" which are "reasonable to say that he may have had pleural plaques related to asbestos exposure." He opined the poor quality was a result of overexposure which would tend to reduce or understate the degree of asbestosis markings. Although he concluded the last x-rays appear to indicate improvement or regression of markings, he also acknowledged that those films were the most overexposed and, thus, the most understated of all the x-rays. He noted that the CT scan was of good quality, which did not understate the markings and thus most likely to reflect the true condition of Decedent's lungs. Dr. Bass also acknowledged that Decedent had increased markings on some of the

x-rays and on his CT scan which "possibly could be parenchymal asbestosis." He determined that he could not make a conclusive diagnosis from Decedent's x-rays and CT scan. When asked to review Dr. Fraser's report and opinion, which he had not reviewed before his deposition, Dr. Bass testified that he saw nothing to alter his opinion, without any further explication.

Clearly, the consensus of medical opinion differs greatly from the opinion offered by Dr. Bass, whose opinion I accord with less weight since he expressed uncertainties about the record medical evidence and needed additional medical studies to confirm his conclusions. Dr. Fraser's uncontradicted opinion, as buttressed by the opinions of treating and consultative physicians, meets the clinical criteria of recognized value of the ATS Statement. I find and conclude that Decedent had radiographic abnormalities consistent with asbestosis.

The objective evidence of Decedent's restrictive impairment and reduced forced vital capacity is contained in the results of the pulmonary function study conducted by Dr. Saucier on May 27, 1994. He opined that Decedent had a severe reduction in forced vital capacity and a severe degree of ventilatory impairment with characteristics of both obstructive and restrictive components. Upon reviewing the pulmonary function study, Drs. Petroff, Gibbs and Lorino concurred with Dr. Saucier's conclusions that Decedent's readings were abnormal.

Although recognizing that Decedent had a compromised respiratory system, Dr. Bass opined the pulmonary function study was suspect. He based his conclusion on an assumption, which was neither explained nor supported by independent evidence, that the study was performed using the "nitrogen washout technique" which results in falsely low lung volume measurements, thus eliminating the restrictive component. I give no credence to his assumption, without further explication, which is pure speculation. He also opined that the readings were tainted by the predicted values used in view of Decedent's age.

Notwithstanding the foregoing, Dr. Bass opined that the literal numbers reflected on the pulmonary function study disclosed that Decedent had both an obstructive and restrictive component. He conceded that, if the readings are accurate, Decedent has two diseases, COPD and pulmonary fibrosis. He acknowledged that a restrictive impairment can be caused by asbestosis. He further opined that Decedent's major respiratory problem was COPD which was more contributing than the

restrictive component to his respiratory problem. If Decedent had asbestosis, Dr. Bass opined that the majority of his impairment was obstructive, however neither contributed to Decedent's death according to Dr. Bass. He had no opinion about the cause of Decedent's death.

The record contains no other pulmonary function studies or readings. Although Dr. Bass questioned the accuracy of the readings, I am not convinced the pulmonary function study reflects inaccurate readings. No objectively based explanation was elicited from Dr. Bass or any other physician which diminishes the value to be assigned the study. Accordingly, I accept the pulmonary function study as accurate and probative of Decedent's abnormal respiratory condition.

Lastly, the medical records document rales or crackles on examination of Decedent which meets the fourth recognized value of the ATS Statement. On June 17, 1994, Dr. Petroff detected crackles on examination of Decedent. During the March 2000 hospitalization at Atmore Community Hospital medication was prescribed to Decedent "because of few crackles in his lungs." Dr. Moore detected rales on September 13, 2000 and Dr. Gandy noted scattered rales on September 14, 2000, while Decedent was hospitalized at Atmore Community Hospital.

Having reviewed Decedent's medical reports, Dr. Bass saw not one instance of physical findings of crackles. He affirmed that the significance of the presence of crackles is that the most likely thing to cause crackles would be pulmonary fibrosis and that crackles do not go away. When he was directed to Dr. Petroff's 1994 findings of crackles, he responded that other physicians had not found crackles. In addition to Dr. Petroff, Drs. Gandy and Moore documented crackles or rales in 2000. Dr. Bass's testimony that rales or crackles were not documented is not persuasive.

Based on the foregoing, I find and conclude that, in addition to the necessary criteria for diagnosis of asbestosis, three of the four recognized values of the ATS Statement are present in Decedent's medical records. Additionally, Drs. Fraser, Petroff, Arcement, Adams, Gibbs and Lorino opined that Decedent suffered from asbestosis.

As noted by Counsel for Claimant, Dr. Bass agreed that the radiographic evidence suggests Decedent had asbestosis. Dr. Bass admitted that Decedent displayed symptoms characteristic of asbestosis with shortness of breath and nonproductive cough.

Lastly, he agreed that the pulmonary function test indicates Decedent had a restrictive impairment component and that restrictive defects can be caused by asbestosis. If the numbers on the pulmonary function test are accurate, and it is noted that there is no credible evidence of record refuting the readings, Dr. Bass admitted Decedent had two diseases, COPD and pulmonary asbestosis. Dr. Bass never testified that Decedent did not have asbestosis, only that he was not convinced that asbestosis was present.

I find and conclude on the basis of the foregoing analysis that Decedent suffered from asbestosis.

b. Did asbestosis contribute to Decedent's death?

Based on Decedent's history, asbestosis was listed as a contributing cause of his death by his treating physicians, Drs. Moore and Gibbs.

Dr. Lorino opined that Decedent's exposure to asbestos contributed to his death in terms of pulmonary dysfunction "as one of the diseases he had along with obstructive lung disease." He further opined that only one interstitial lung disease causes abnormal pulmonary function readings like Decedent's when asbestos exposure, pleural plaques and fibrosis are present, and that is pulmonary asbestosis. He explained that Decedent had two problems (COPD and asbestosis) and both were contributing diseases. He confirmed there is no way to attribute a percentage of cause to either process, and it was not possible that only one disease process could be causing all of Decedent's symptoms and study results. He opined that Decedent had respiratory failure and asbestosis contributed to his death.

Dr. Bass stands alone in his opinion that asbestosis did not cause or contribute to Decedent's death. Counsel for Claimant correctly points out that the gist of Dr. Bass's opinions is (1) he does not know what caused Decedent's death; (2) he was no convinced that asbestosis was a factor; and (3) if asbestosis was a factor, it was not a **major** factor. Dr. Bass had no opinion as to the cause of Decedent's death. He did not believe the 1994 pulmonary function study showed severe enough lung impairment to have been a significant cause of Decedent's death. As noted by Counsel for Claimant, it was not Decedent's 1994 lung condition which caused his death, but his 2000 lung condition. Dr. Bass did not have enough evidence to agree or disagree with the cause of Decedent's death listed on his Certificate of Death by Dr. Gibbs.

Assuming the accuracy of the pulmonary function test, even Dr. Bass admitted that Decedent most likely had an asbestosis condition that contributed to his pulmonary deficiency.

The Act does not require a showing that Decedent died exclusively from a work-related occupational disease. Employer has failed to produce credible, specific and comprehensive evidence that Decedent's death was not caused, at least in part, by asbestos exposure and asbestosis. Furthermore, consistent with the Eleventh Circuit's decision in Brown, supra, no physician expressed an opinion **ruling out** the possibility that there was a causal connection between Decedent's asbestos exposure, his resulting asbestosis and his death. Accordingly, I find and conclude that Decedent's death was caused, in part, by his asbestos exposure during employment with Employer and his resulting pulmonary deficiency caused, in part, by his asbestosis or pulmonary fibrosis. Therefore, Claimant is entitled to death benefits and reimbursement of funeral expenses.

B. Death Benefits

Section 9 of the Act provides in pertinent part:

> If the injury causes death, the compensation therefore shall be known as a death benefit and shall be payable in the amount and to or for the benefit of the persons following:
>
> (a) Reasonable funeral expenses not exceeding $3,000,
>
> If there be a widow or widower and no child of the deceased to such widow or widower 50 per centum of the average wages of the deceased, during widowhood . . . .
>
> (e) In computing death benefits, the average weekly wages of the deceased shall not be less than the national average weekly wage as prescribed in section 6(b), but-
>
> (1) the total weekly benefits shall not exceed the lesser of the average weekly wages of the deceased or the benefit which the deceased employee would have been eligible to receive under section 6(b)(1); and
>
> (2) in the case of a claim based on death due to an occupational disease for which the time of injury (as determined under section 10(i)) occurs after the employee

has retired, the total weekly benefits shall not exceed one fifty-second part of the employee's average annual earnings during the 52-week period preceding retirement . . . .

Thus, having found Claimant has established that Decedent had asbestosis which contributed, in part, to his death, Claimant is entitled to widow benefits at the stipulated rate of $150.00 per week from September 25, 2000, to the present and continuing in accordance with Section 9(e)(2) of the Act.

Moreover, although Claimant incurred funeral expenses in the amount of $6,226.00, she is only entitled to reimbursement of funeral expenses in an amount up to $3,000.00 pursuant to Section 9(a). (CX-6). Accordingly, Employer is responsible for reimbursing Claimant for funeral expenses in the amount of $3,000.00. See Bingham v. General Dynamics Corp., 20 BRBS 198, 205 (1988).

V. SECTION 14(e) PENALTY

Section 14(e) of the Act provides that if an employer fails to pay compensation voluntarily within 14 days after it becomes due, or within 14 days after unilaterally suspending compensation as set forth in Section 14(b), the Employer shall be liable for an additional 10% penalty of the unpaid installments. Penalties attach unless the Employer files a timely notice of controversion as provided in Section 14(d).

In the present matter, the parties stipulated that Employer was notified of Decedent's death and notice of claim on June 20, 2002. It is further stipulated that Employer filed a notice of controversion on July 19, 2002. Employer's knowledge of Decedent's death triggers a duty to pay or controvert. See generally Benn v. Ingalls Shipbuilding, Inc., 25 BRBS 37, 39 (1991), aff'd sub nom. Ingalls Shipbuilding v. Director, OWCP, 976 F.2d 934, 26 BRBS 107 (CRT)(5th Cir. 1992).

In accordance with Section 14(b), Claimant was owed compensation on the fourteenth day after Employer was notified of Decedent's death. Thus, Employer was liable for Claimant's widow benefits on July 4, 2002, or the first business day thereafter, July 5, 2002. Since Employer controverted Claimant's right to widow benefits, Employer had an additional fourteen days within which to file with the District Director a notice of controversion. Frisco v. Perini Corp. Marine Div., 14 BRBS 798, 801, n. 3 (1981). A notice of controversion should have been filed by July 19, 2002, to be timely and prevent the

application of penalties. Consequently, I find and conclude that Employer filed a timely notice of controversion on July 19, 2002, and is not liable for Section 14(e) penalties.

VI. INTEREST

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. Avallone v. Todd Shipyards Corp., 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP, 594 F.2d 986 (4th Cir. 1979). Interest is also payable on all accrued unpaid death benefits, including funeral expenses, from the date of death, September 25, 2000. Smith v. Ingalls Shipbuilding Division, Litton Systems, Inc., 22 BRBS 46 (1989).

The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills . . . ." Grant v. Portland Stevedoring Company, et al., 16 BRBS 267 (1984). This order incorporates by reference this statute and provides for its specific administrative application by the District Director. See Grant v. Portland Stevedoring Company, et al., 17 BRBS 20 (1985). The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

VII. ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit an application for attorney's fees.[4] A

[4] Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only

service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

VIII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

1. Employer shall pay to Claimant's widow, Lila Kendrick, widow benefits at the rate of $150.00 per week from the date of Decedent's death on September 25, 2000, to present and continuing in accordance with Section 9 of the Act. 33 U.S.C. § 909(e).

2. Employer shall pay to Claimant's widow, Lila Kendrick, funeral expenses in the amount of $3,000.00. 33 U.S.C. § 909(a).

3. Employer shall receive credit for all compensation heretofore paid, as and when paid.

4. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

5. Claimant's attorney shall have thirty (30) days from the date of service of this decision by the District Director to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be served on Claimant and

---

the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. Revoir v. General Dynamics Corp., 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. Miller v. Prolerized New England Co., 14 BRBS 811, 813 (1981), aff'd, 691 F.2d 45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **January 31, 2003**, the date this matter was referred from the District Director.

opposing counsel who shall then have twenty (20) days to file any objections thereto.

ORDERED this 14th day of April, 2004, at Metairie, Louisiana.

A

LEE J. ROMERO, JR.
Administrative Law Judge